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The Evolving Role and Care Management Approaches of Safety-Net Medicaid Managed Care Plans

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ABSTRACT *This article provides new empirical data about the viability and the care management activities of Medicaid managed-care plans sponsored by provider organizations that serve Medicaid and other low-income populations. Using survey and case study methods, we studied these "safety-net" health plans in 1998 and 2000. Although the number of safety-net plans declined over this period, the surviving plans were larger and enjoying greater financial success than the plans we surveyed in 1998. We also found that, based on a partnership with providers, safety-net plans are moving toward more sophisticated efforts to manage the care of their enrollees. Our study suggests that, with supportive state policies, safety-net plans are capable of remaining viable. Contracting with safety-net plans may not be an efficient mechanism for enabling Medicaid recipients to "enter the mainstream of American health care," but it may provide states with an effective way to manage and coordinate the care of Medicaid recipients, while helping to maintain the health care safety-net for the uninsured.*

INTRODUCTION

Medicaid managed-care plans sponsored by provider organizations that serve Medicaid and other low-income populations have assumed an increasingly important role in the Medicaid program in recent years as commercial competitors have been leaving the field. The creation of these Medicaid-financed delivery systems—what we call safety-net health plans because of the nature of their sponsoring organizations—entails a largely unrecognized shift in the conceptual underpinnings of Medicaid managed care. Enrollment in managed-care plans was supposed to enhance Medicaid enrollees' access to mainstream medical care. Providing such access was long seen as a way to ensuring that the medical care received by the poor is comparable to that received by the rest of society. The idea of safety-net providers such as community health centers and public hospitals creating their own health plans thus signals a retreat from the "mainstreaming" approach to quality of care in Medicaid.

But, managed care itself has been offered as a path toward improved quality of services for the poor. If safety-net health plans actually engage in care-management

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activities that increase the likelihood that patients receive needed services and that patterns of care are monitored, this could well be a more effective path toward quality than is mainstreaming.

Thus, the creation of Medicaid plans sponsored by safety-net providers entails a tension between two approaches toward improved care for America's poor. Should the move away from the mainstreaming goal be viewed as a cause for concern? Or, is the creation of safety-net plans a sound way to improve the care of Medicaid beneficiaries within the framework of organizations that have the long-term mission of serving this population?

The answers to such questions depend on how safety-net plans negotiate the twin dangers that are involved in the provider sponsorship of health plans. One danger pertains to plan viability. Plans and providers have conflicting economic interests since providers' revenues (which they presumably seek to enhance) are the plan's expenditures, which they must control to survive. The second danger pertains to quality. Providers seldom welcome the attention of managed-care plans, but if safety-net plans are to make a difference in the quality of medical care that enrollees receive, they must take an active management and monitoring role. Provider-sponsors could be expected to favor minimizing such a role by plans. As a consequence, plan sponsorship by safety-net providers could entail the sacrifice of the mainstreaming goal with no redeeming benefit.

This article provides new empirical data about the viability and the care-management activities of safety-net Medicaid plans. It is based on two surveys of such plans carried out in 1998 and 2000.

BACKGROUND: THE EVOLVING ROLE OF SAFETY-NET PLANS

An early goal of the Medicaid program was to provide enrollees with entry into the health care system used by the insured population. The idea was that "Medicaid would allow low-income citizens to use providers of their choice, to enter the mainstream of American health care."[1] In reality, the traditional fee-for-service Medicaid program never achieved this goal. Access to physician services has been a chronic problem for beneficiaries for most of the program's history because of its being seen as a "welfare" program and because Medicaid generally paid physicians much lower rates than did other insurers. As early as 1974, Stevens and Stevens[2] described Medicaid as perpetuating a two-class system of medical care in which middle- and upper-income people use private hospitals and physicians, and the poor use a fragmented public system.[2]

The idea of managed care for Medicaid recipients offered new hope that the program would provide access to mainstream providers and services.[3–5] Cost control was a driving force behind the adoption of Medicaid managed care, but reformers also envisioned managed-care organizations (MCOs) using their market-based leverage to convince more private physicians to participate in the Medicaid program. Plans created by commercial insurers, it was hoped, not only would provide access to mainstream providers, but also would eliminate the stigma associated with Medicaid since their enrollees would present a private insurance card to their provider and thus not be identified as a Medicaid recipient.

In the early 1990s, nearly every state in the country created a managed-care program for Medicaid. Enrollment in managed care grew from 9.5% of the Medic-

aid population in 1991 to over 54% in 2000, and the percentage would be much higher if the long-term care population were excluded.

The rise of Medicaid managed care threatened the community health centers, public hospitals, and teaching hospitals that had long served as the medical safety net for the nation's poor. Medicaid revenues were an essential component of their often-fragile financial structures, and enrollment of Medicaid beneficiaries in managed-care plans raised two risks. First, patients might be lost to providers made available to beneficiaries by the plans. Second, to continue treating Medicaid patients, safety-net providers would need to enter into contractual arrangements with managed-care plans and have to accept cuts in payment rates and cede some control over patient care to organizations for which patient care might not be the first priority.

Faced with the prospect of growing Medicaid enrollment in managed care, some safety-net providers concluded that their chances of surviving and fulfilling their missions would be improved if they created their own plans. As one health center director explained, "It's a question of where you want to be in the future. If you want to be down the end of the food chain, you stay as a regular provider . . . but if you care about where you position yourself to influence public policy, it was pretty clear you wanted to be sitting at the table."[6]

A few safety-net health plans were created in the 1980s, but most of the plans in existence in the late 1990s had been started in the early to mid-1990s. Our 1998 survey of safety-net plans found that most were still quite young, relatively small, and did not have a significant portion of the Medicaid enrollment in their markets. However, the role of such plans appears to be becoming more important, in part because of changes involving commercial plans.

By the late 1990s, however, commercial MCOs started to leave the Medicaid market, dissatisfied with the rates paid by the states, as well as the regulatory requirements attached to the program.[7,8] Both the number of commercial plans participating in Medicaid managed care and the percentage of Medicaid recipients in commercial plans began to decline in 1997. Medicaid managed care relied increasingly on the growing Medicaid-dominated plans (defined in one study as "full-risk managed care plans, in which Medicaid enrollment makes up 75% or more of total enrollment").[9(p.iii)] Many of these are the safety-net plans sponsored by provider organizations with a long-term commitment to serving the Medicaid and other low-income populations.

This commitment has made these organizations more willing to stay with the Medicaid program even as their commercial counterparts were abandoning it. Their ability to do so, however, depends on their financial stability, and this is a matter of concern.[10–13] Because of the likely future importance of safety-net plans in Medicaid managed care, it is important to understand what is happening to them in the current turbulent environment.

In 1998, the New York Academy of Medicine (NYAM) and Columbia University conducted a collaborative study of safety-net plans. This article reports on the results of a new survey of the safety-net plans that was carried out in 2000. In the next section, we describe our research methods. We then present information on plans that have closed since our 1998 survey and the changing characteristics of the population of safety-net plans. Finally, we add more substance to one of the most striking findings from the first study: despite the expectation that these plans might be little more than conduits of state funds to providers, plans reported making extensive use of managed-care tools such as various prior authorization require-

ments and case management. This suggested that these plans might be influencing the care that enrollees receive. This bears on the important policy concern about the ability of Medicaid managed-care plans to improve the quality of care delivered to their enrollees.[14,15]

METHOD

The article compares data from the 1998 study of safety-net plans with two complementary sources of data from a similarly designed new study carried out in 2000: (1) a national survey designed to track changes in this set of organizations and to follow up on key issues identified in the first survey and case studies; (2) case studies that explore the approaches of plans to carry out managed care.

National Survey

As in 1998, survey data were collected in 2000 by a mailed questionnaire supplemented by telephone follow-up. The questionnaire focused on sponsorship and enrollment; delivery system; care-management methods; relationships with sponsoring organizations; financial performance; and environment and state policy. After some nonresponding organizations indicated that they did not have time to complete our survey instrument, we asked them to complete a short form of the survey that focused on core information. We obtained data from 56 of the 83 safety-net plans that we were able to identify, a response rate of 67%.

Case Studies

To compliment and add depth to the national survey, we conducted site visits at six safety-net plans: the Bronx Health Plan (NY), Care Oregon (OR), Care Source (OH), Health Partners (PA), Mercy Care Plan (AZ), and Neighborhood Health Plan of Rhode Island. At least two members of our team went on these 2-day visits and met with several staff members, including the chief executive officer (CEO) and medical director of the plan, as well as with senior officials of at least two of the plan's provider-sponsors and the state Medicaid director or other key state officials.

To learn more about the changing circumstances of the plans, we also did in-depth phone interviews with the CEOs and/or medical directors of the four plans that were site visited during the 1998 study. These included Colorado Access (CO), Community Premier Plus (NY), Family Health Partners (MO), and Neighborhood Health Plan of Boston (MA).

Identification of Safety-Net Plans

Using lists from the Health Services Resources Administration (HRSA) and the National Association of Public Hospitals (NAPH), along with information from the *InterStudy Competitive Edge HMO Directory*[16] of March 1998, state Medicaid offices, and health plans themselves, the 1998 study identified 99 plans that appeared to be sponsored by safety-net provider organizations. We updated the list for the 2000 survey using the same methodology and learned that 4 plans from our list of 99 had closed, and 4 others had stopped participating in Medicaid.

After pretesting the survey with executives of 3 safety-net plans in three states, the survey was mailed to 91 plans that remained on our list. Based on information gathered from follow-up calls, we eliminated 15 additional plans: 10 that had closed, 2 that no longer served the Medicaid population, and 3 that were not actually sponsored by safety-net providers. On the other hand, respondents to the 2000

survey helped us identify 7 additional safety-net plans in their states. Thus, we ended up with a list of 83 safety-net plans that were in operation in 2000.

Information On Closed Plans

To seek reasons for the failure of safety-net plans, we sought information about plans that had closed as well as about those that had left the Medicaid market. We had data from our 1998 survey about 9 plans that subsequently closed, and we were able to obtain some information about 2 additional plans from newspaper accounts. We also had telephone conversations with executives of 2 of these plans. We were unable to obtain any information about the other 4 that had closed.

CLOSURES AND MERGERS

In conducting our 2000 survey, we identified 14 plans that had closed since the first survey and 6 others that had stopped participating in Medicaid, but continue to operate other lines of business. This represents a noteworthy number of the 104 safety-net plans that we confirmed existed in the 1997–2000 period. Whether particular plan characteristics are associated with closure or exit from Medicaid managed care is an important question.

Characteristics of Plans That Failed

The information we obtained reveals no characteristics that were shared by plans that failed. Of the plans that closed, hospitals were the lead sponsor of 9, health centers of 3, and a consortium of safety-net providers of 2. Of the 3 plans that left Medicaid and about which we could identify sponsorship, 2 were sponsored by health centers and 1 by a nonprofit hospital. (None of these plans retained a formal affiliation with their original sponsor.) The sponsorship composition of the failing plans is similar to the composition of the plans that was revealed in our 1998 survey (64% sponsored by hospitals or academic health centers, 23% by community health centers, and 10% by consortiums).

The 8 plans for which we have data on relationships with sponsors, model type, age, and enrollment appear similar to surviving plans on those dimensions. Half were self-governing, and three quarters were separately incorporated subsidiaries. About one third reported that some decisions were subject to the review of their sponsor(s), and more than 80% reported sharing some senior staff with their sponsor(s). About one half of these plans were IPA models, and the others were either mixed or mixed with group dominant models. The majority of the closed plans had been less than 2 years old in 1998. All of the plans had reported growing numbers of enrollees in that survey, although their growth rates started to diminish after 1995.

The closed plans were more likely than the other plans that responded to the 1998 survey to be Medicaid only (63% vs. 37%). In our previous study, we found that Medicaid-only plans were particularly likely to lose money. However, only a slightly higher percentage of plans that closed had reported in 1998 that they had lost money the previous year (75% vs. 60% for other plans in the survey). A smaller percentage of the closed plans (17% vs. 28%) had reported that access to capital was a major problem. About the same percentage of closed and surviving plans (67% vs. 70%) had reported that state reimbursement rates were either "very" or "slightly" problematic. Two of the plans that left the Medicaid program cited inadequate Medicaid managed-care rates as the primary reason.

Information from the two plans that we contacted by telephone attributed failure to a combination of low Medicaid rates and poor management. According to the CEO of one plan, the original management team's lack of experience with managed care exacerbated the problem of low state Medicaid rates. "The state lacked confidence in the existing management, and they were unwilling to adjust the rates. When we brought in new management team, we were able to provide a better justification for our rate requests." By the time the plan made these changes, however, it had "already accumulated a lot of debt, so when the possibility of an acquisition came along, it made sense to go in that direction" (Michael Gusmano, personal communication; the CEO of this plan asked to remain anonymous).

For the two plans for which our information came from newspaper accounts, the financial performance did not seem to be a primary factor behind the decisions to close these plans. Grady Healthcare in Atlanta was losing money—approximately $8.5 million between 1997 and September 1999. Yet, according to the former chairman of the board, the plan's losses were lower than those of most of the other start-up health maintenance organizations (HMOs) in Georgia and were consistent with the projections that the plan presented to the Georgia Department of Insurance when it applied for its HMO license.[17,18] Grady Healthcare closed because the state terminated its Medicaid contract with the plan.

In East St. Louis, St. Mary's hospital decided to sell Neighborly Care Plan to Harmony Health Plan because hospital officials did not believe they had sufficient capital to invest in Neighborly Care's management capacity. Unlike the majority of the plans that closed or were sold, Neighborly Care Plan actually made a small profit in its last year of operation.[19]

HOW SAFETY-NET PLANS ARE CHANGING

In terms of many organizational characteristics, the safety-net plans of 2000 were quite similar to those of 1998. That is not surprising in a brief period of time. However, we found evidence that a major shift has been taking place in the delivery systems by which these plans provide care for their enrollees. The most striking change has been in the growing size and the improved financial health of the safety-net plans.

Sponsorship and Organizational Form

As in 1998, safety-net plans reflect the diversity of the organizations that serve low-income populations. The majority of plans are sponsored by hospitals or health centers (Table 1). Two plans had several types of sponsors, with none playing a lead role.

Most plans are organized as nonprofit organizations (55%), but 18% of the plans are for profit, and 27% are government owned. Again, this distribution is very similar to that of the 1998 study findings.

TABLE 1. Leading sponsor type

Health center (N = 16)	29%
Hospital (N = 24)	43%
Other (N = 14)	25%
Group (N = 2)	3%
Total (N = 56):	100%

Source: 2000 Safety-Net Plan Survey.

Plan Autonomy

Sponsor limitations on the autonomy of safety-net plans continue to be common. Although most plans (94%) have their own governing boards, 13% indicate that some types of decisions can be made only by the sponsoring organization, and another 25% indicate that at least some board decisions are subject to review by the sponsoring organization. Furthermore, as in 1998, most plans report that their board members are chosen by the sponsoring organization, and the CEOs of virtually all plans report to these governing boards.

Age

The safety-net plans surveyed in 1998 were relatively young, with an average age of only 4.7 years. Only 26% of plans were 5 or more years old; 33% were less than 2 years old. Not surprisingly, the plans in the current sample are a bit older. Only 3 of the 56 plans (6%) that responded to the 2000 survey started enrolling Medicaid recipients less than 3 years previously; nearly half (48%) started enrolling Medicaid recipients between 3 and 5 years earlier, and almost one third of the plans were at least 10 years old.

Delivery System and Model Type

As we found in 1998, sponsoring organizations continue to make up a significant portion of most the delivery systems of most plans (Table 2). Half of their Medicaid enrollees receive primary care through a sponsor organization, and about half of specialist visits are to providers affiliated with a sponsor organization. However, the percentage of visits to sponsor-affiliated specialists differed greatly by sponsor type. For plans sponsored by community health centers, the median percentage of specialist visits to providers affiliated with a sponsor organization was only 26%, while plans with other sponsor types provided most of their specialty care through the sponsors.

Although at least part of the delivery system for most safety-net plans is owned by provider organizations, the majority of plans use managed-care models that facilitate contracting with additional providers. In the 1998 survey, only 33% of plans reported that their predominant model type was group/health centers, and in the 2000 survey, only 14% reported using these model types. The IPA/network model was used by 40% of the plans in 1998, and another 28% said that they used a mixture of models. In 2000, fewer plans report using an IPA model, but a much larger percentage of the plans (60%) use a mixture of models. Plans sponsored by health centers reported using an IPA/network or mixed model much less frequently

TABLE 2. The role of sponsoring organizations in plan networks

	Medicaid patients receiving primary care through sponsor organizations, %	Specialist visits to providers affiliated with a sponsor organization, %
Overall	50 (n = 38)	48 (n = 27)
By leading type of sponsor		
Health centers	45 (n = 10)	26 (n = 7)
Hospitals	55 (n = 17)	70 (n = 12)
Other	45 (n = 11)	75 (n = 8)

Source: 2000 Safety-Net Plan Survey.

than other types of plans in 1998, but this is no longer the case. In the 2000 survey, 82% of plans sponsored by health centers reported using either an IPA or mixed model compared to 88% for all of the respondents.

Several safety-net plans told us that, while they have expanded the number of private physicians in their networks in recent years, most of these physicians only see a few of their enrollees. Over 40% of the primary care providers (PCPs) in the Medicaid networks of the plans practice in private offices. Furthermore, only 30% of the PCPs of the hospital-sponsored plans are based in hospitals, and only 33% of the PCPs in plans sponsored by community health centers practice in health centers. Yet, half of the members in hospital-sponsored plans receive their primary care in a hospital clinic, and more than half of the members in health-center-sponsored plans receive their primary care in a health center. So, these plans are at least a partial success in steering Medicaid business to their sponsoring organizations.

GROWTH TRENDS AND FINANCIAL SUCCESS

Growth Trends

Plans responding to the 2000 survey reported substantially higher total enrollment, Medicaid enrollment, and Child Health Insurance Program (CHIP) enrollment than did the respondents to the 1998 survey. Between 1997 and 1999, the median total enrollment in safety-net plans increased from about 26,000 to 41,000. The median Medicaid enrollment increased from 25,000 to just over 30,000. The median CHIP enrollment increased dramatically, from 841 to over 4,100. There has also been a significant growth in the percentage of plans with total enrollments of 25,000 or more (Table 3). This is important because of the strong correlation between plan size and profitability.[20]

These increases could be an artifact of the failure of small plans between our two survey years. Comparison of the enrollment figures for the 47 plans that provided data in both surveys suggests that this is not the case. Between 1997 and 2000, the median total enrollment among these plans increased from approximately 26,000 to nearly 41,000, median Medicaid enrollment increased from 25,000 to

TABLE 3. Total plan enrollment

	10,000 or less, %		10,001–25,000, %		25,000+, %		Total, %	
	1997	1999	1997	1999	1997	1999	1997	1999
Total enrollment (1997, n = 75; 1999, n = 54)	24	9	25	17	51	74	100	100
By leading type of sponsor								
Health center (1997, n = 13; 1999, n = 16)	33	9	17	9	50	82	100	100
Hospital (1997, n = 37; 1999, n = 24)	24	17	35	17	41	66	100	100
Other (1997, n = 19; 1999, n = 14)	13	—	13	27	74	73	100	100

Source: 1997 figures are from the 1998 Safety-Net Plan Survey; 1999 figures are from the 2000 Safety-Net Plan Survey.

nearly 28,000, and median CHIP enrollment increased from 972 to over 2,400. This means that the average (surviving) safety-net plan grew by almost 60% in the 2 years between our surveys, a period during which commercial plans were rapidly exiting the Medicaid market. Indeed, our case studies suggest that some enrollment gains in safety-net plans are the result of the exit of other plans from the market.

Increases in Medicaid enrollment were most dramatic in plans sponsored by health centers. The median Medicaid enrollment in health center plans jumped from just under 20,000 in 1997 to 40,000 in 1999.

Although both Medicaid and CHIP enrollment have grown substantially since 1997, overall commercial, Medicare, and other enrollment have not changed substantially since the last survey. These other product lines continue to represent a small percentage of the enrollment in most safety-net plans. Only 13 safety-net plans reported having commercial enrollees in 1999, and most of these plans have fewer than 10,000 commercial members. Three hospital-sponsored plans, however, have more than 50,000 commercial enrollees.

Profitability

Overall, safety-net plans were much healthier in 2000 than were the plans surveyed in 1998 (Table 4). Only about one third of the plans reported then that they had showed a surplus in 1997, and another 8% broke even. By contrast, 65% of the plans reported a surplus in 1999, and 14% broke even. The percentage of plans that reported losing money dropped from 60% to 22%. In 1997, plans sponsored by health centers and governments were the only types in which a majority did not lose money. In 1999, a majority of plans from every sponsorship category showed a surplus.

As in the 1998 survey, the magnitude of losses experienced by the money-losing plans was greater than the magnitude of the surpluses reported by the plans that made money. The median amount lost by money-losing plans was $132 per member in 1999 compared to $107 in 1997, while the amount made by profitable plans was $33 per member in 1999 compared to $28 in 1997. (These are current dollar figures.) Our findings with regard to profits and losses must be interpreted with caution. Only 4 of the 11 plans that reported losing money in 1999 reported how much they lost, while 30 of the 34 profitable plans reported how much they made.

TABLE 4. Reported financial performance, 1997 and 1999

	Made money, %		Broke even, %		Lost money, %	
	1997	1999	1997	1999	1997	1999
Overall (1997, n = 74; 1999, n = 52)	32	65	8	14	60	22
Health centers (1997, n = 16; 1999, n = 14)	50	72	6	14	44	14
Hospital (1997, n = 39; 1999, n = 23)	18	61	10	22	72	17
Other (1997, n = 19; 1999, n = 15)	47	66	5	—	47	34

Source: 1997 figures are from the 1998 Safety-Net Plan Survey; 1999 figures are from the 2000 Safety-Net Plan Survey.

Our1998 study found that plan age, size, and product diversification were associated with profitability. The results of the 2000 survey continue to show a strong correlation between size and profitability. Only 25% of the plans with a total enrollment of 10,000 or less reported making a profit in 1999, but 40% of the plans with a total enrollment between 10,001 and 25,000 and 79% of the plans with a total enrollment over 25,000 reported making a profit in 1999. There does not, however, appear to be any relationship between profitability and age or diversification among plans that responded to the 2000 survey.

The growth in the percentage of safety-net plans reporting a surplus does not appear to be due to the elimination of plans that either closed or dropped out of the Medicaid program. Of the plans that responded to both surveys, 62% reported a surplus in 1999 compared with 38% in 1997; the percentage of these plans that reported breaking even increased from 3% to 15%, and the percentage that reported losing money dropped from 59% to 19%.

Many of the surviving plans have been helped by the decision of commercial plans to reduce or eliminate their Medicaid enrollment. In at least some communities around the country, safety-net plans have become the dominant player in the Medicaid market. Changes in state Medicaid reimbursement and the adoption of other supportive state policies are other reasons for the improvement in safety-net plan financial status. In 1998, most plans reported that Medicaid reimbursement rates and state policies regarding marketing were "somewhat" or "very" problematic. There is still a great deal of concern about state marketing policies, but plans are somewhat less critical of state Medicaid rates. Fewer than 40% of the respondents to the 2000 survey reported that state Medicaid rates for Temporary Assistance for Needy Families (TANF) enrollees were somewhat or very problematic, and nearly half reported that the rates for these enrollees had improved. Most of our site visit plans reported that state Medicaid rates had improved during since 1997.

We also found examples of other financial mechanisms used by states to support safety-net plans. Rhode Island, for example, negotiated a risk-sharing relationship with Neighborhood Health Plan of Rhode Island. According to plan officials, their ability to show a profit since 1997 is partly due to this arrangement.

Although the financial health of these plans has improved, they continue to face significant cost pressures, including rapid increases in prescription drug costs. Nearly all plans that we visited voiced concerns about escalating drug and emergency care costs.

CARE MANAGEMENT IN SAFETY-NET PLANS

If active care-management activities by health plans are necessary to improve the care of an enrolled population, provider sponsorship has a potential disadvantage. It is well known that the care-management activities of health plans are often resisted and resented by providers. Having control of a health plan sounds like a provider's fantasy. A reasonable question, therefore, is whether provider-sponsored plans will engage in active care-management activities or whether they will essentially serve as little more than entities through which Medicaid funds pass between the state and providers.

We touched on this question in our 1998 survey, but looked at it in much more detail in the 2000 survey. In 1998, we asked plans about the use and importance to the plan of seven care-management practices. Almost all reported using these

standard, and potentially conflict-generating, managed-care practices, including precertification of elective hospital admissions, concurrent review of hospital stays, prior authorization of outpatient procedures and specialty services, case management, and practice guideline dissemination. More than 70% reported that they were doing provider profiling.

In the 2000 survey, we sought to understand better the substance behind these numbers by asking more detailed questions about such matters as frequency and purposes of use of different managed-care tools. Despite the differences in question wording, the findings are similar. Most of the management techniques are used by 90% of the plans or more, and most plans use them regularly (Table 5).

The one noteworthy exception is "prior authorization of specialty services," the use of which has clearly declined. Only 33% of the plans "regularly" require prior authorization of specialty services. Another 30% require it "occasionally." Moreover, as we learned during our site visits, even when plans require prior authorization for specialty services, they do not always vigorously enforce the requirement. One plan told us that, if the specialist is in the plan's network, they simply "rubber stamp" referral requests. That plan may act if a patient is referred to a specialist who is outside the network, but the reason is not to prevent the use of specialty services, but rather to pursue a contractual relationship with the new specialist. Another plan told us that it continues to maintain a formal policy of requiring that prior authorization be requested for specialty care because of its presumed sentinel effect in discouraging overutilization of specialists. But, as in the other plan, no actual review of the appropriateness of the referral decision or the need for specialty services is done.

The widespread decision to abandon prior authorization requirements for specialty referrals appears to be related to the perceived costs and benefits of this activity. More than half of the plans reported that the costs of requiring prior authorization for specialty services exceed the savings. In fact, the only managed-care tools that were viewed by a majority of plans as producing more savings than costs were concurrent review of hospitalizations and the use of a drug formulary with authorization requirements for exceptions. Given the rapid increase in prescription drug costs in recent years, the value placed on the latter is notable.

TABLE 5. Managed-care technique by frequency of use, 2000

How important are the following medical management practices to the plan?	Regularly, %	Occasionally, %	Not now, %	Previously, %	Total, %
Precertification of elective hospital admissions (N = 49)	92	6	2	0	100
Concurrent review (N = 50)	90	10	0	0	100
Prior authorization of outpatient procedures (N = 49)	80	16	2	2	100
Prior authorization of specialty services (N = 48)	33	30	21	17	100
Case management (N = 49)	67	27	6	0	100
Disease management (N = 47)	62	26	12	0	100

Source: 2000 Safety-Net Plan Survey.

Analysis of Claims/Encounter Data

Nearly all of the plans (96%) reported that they analyze claims or encounter data from physicians or provider organizations. Safety-net plans use these data to further a combination of financial, utilization management, and quality goals (Table 6).

Whereas in 1998 health center plans were doing much more profiling than were hospital-sponsored plans, that difference had largely disappeared in the 2000 survey as other plans have caught up with health-center-sponsored plans. Health center plans are still more likely to report that "providing physicians with feedback regarding how their utilization patterns compare with other PCPs" is an important purpose, but they are much less likely to report using these data to "identify inappropriate uses" of services and slightly less likely to use these data to "identify quality of care problems."

Data from providers are necessary for a number of important care-management activities related to utilization and quality. But, are plans able to obtain data from providers that are adequate for these purposes? The plans reported that 80% of PCPs and 90% of specialists provide adequate data, although the variation among plans is quite wide. Through our interviews and our site visits, we learned more about the impediments to adequate data collection from providers and what plans are doing to address the issue (this is reported in a separate article).[21]

Tracking Preventive Services

Nearly all safety-net plans report that they track the use of prenatal care, immunizations, the use of well-child care, and the use of well-woman care. What do they do when their data collection efforts identify apparent gaps in preventive services? More than 86% of the plans report that they notify their PCPs when the plan identifies gaps in preventive services, and 81% of the plans report that they identify provider organizations when these gaps are found. A substantial majority of plans (63%) also report that they notify enrollees about apparent gaps in preventive services.

The survey does not tell us how providers are notified about these gaps in

TABLE 6. Importance of the purpose of claims/encounter data analysis (% of plans saying "important")

Purpose for data analysis	Overall, % (N = 50)	Health center, % (N = 13)	Hospitals, % (22)	Other, % (13)	Group, % (2)
To identify possible inappropriate uses	60	9	59	46	100
To identify quality-of-care problems	80	69	91	69	100
Assess sufficient provision of services under cap	64	62	59	69	100
Assess rate adjustments	49	46	44	54	100
Provide feedback relative to other primary care providers	63	75	48	69	100
Provide feedback to compare utilization to standards of care	57	64	52	62	50
Provide medical directors with information on practice patterns of their physicians	54	55	50	62	50

Source: 2000 Safety-Net Plan Survey.

services or what, if anything, happens after they are notified. Some, although not all, of the plans we visited provide regular reports to their providers and meet quarterly with the CEOs and or the medical directors of their provider groups to discuss these data. A few plans also provide financial incentives to providers and provider groups for meeting targets on a number of performance and quality measures. These efforts, however, appear to be both limited and quite recent.

Individual Case Management and Disease Management

Nearly all of the plans provide individual case-management services to their enrollees, and nearly all of the plans have disease-management programs, most commonly for asthma, diabetes, and high-risk pregnancy (Table 7). Almost 30% of these plans have disease-management programs for human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). Only 2 plans reported having programs to address hypertension, although about one quarter of the plans suggested that their providers had programs for these conditions.

An overwhelming majority of the plans with disease-management programs used cost and utilization data in deciding which conditions needed focus. This suggests a level of sophistication in the level of collection and interpretation of data about the care for their members.

Are plans able to document the results for their disease-management programs? This would enable them to assess the extent to which the programs are working and how or whether to continue them. Overall, about half of the plans that have disease-management programs also have some information about the impact of their programs. Most commonly, plans were able to document an increase in preventive services for members in the disease-management programs. Some health center plans were able to document decreased utilization of certain services. Member satisfaction was an outcome that was examined by a few plans. Two plans, both sponsored by hospitals, found an increase in provider satisfaction associated with their disease-management programs.

Despite the impressive number of plans that report having disease-management programs for their Medicaid patients and the limited, but promising, data with regard to their effects, very few plans were willing or able to provide more detailed information about the scope of these programs. Only one quarter of the plans with disease-management programs told us how many members receive these services. Only 12% of plans with these programs gave us an estimate of the number of enrollees who are eligible to participate in the plan's programs.

TABLE 7. Types of disease management programs

(n = 42)	Plan has program	Providers have program	No program available for members
Asthma	80	30	3
Diabetes	60	34	16
High-risk pregnancy	75	25	8
HIV/AIDS	27	25	32
Hypertension	4	23	40

Source: 2000 Safety-Net Plan Survey.

There are several possible explanations for the failure of the plans to provide data about the scope of these programs. Some plans told us that, while this information is in their database, they do not track this information on a routine basis. A number of plans told us that providing it would require a special data run that they were not willing to perform for the purpose of filling out the survey. Other plans delegate all or some disease-management programs to providers and do not know how many people are in these programs. Without more information about the scope of these programs, it is difficult to draw firm conclusions about them. The failure of most plans to provide these data may simply reflect a limitation of the survey instrument. Nevertheless, the fact that so few plans were able to provide information about the number of patients in the disease-management programs of the plans raises some questions about the vigor with which plans are evaluating these programs.

EVOLVING REGULATION OF SAFETY-NET PLAN PERFORMANCE

Increasingly, states are trying to act as "prudent purchasers" of services from Medicaid managed-care plans.[22] Under proposed rules to implement the Balanced Budget Act of 1997 (BBA), states are required to arrange for annual independent, external reviews of quality and access under each Medicaid managed-care plan contract. Under these same rules, plans that participate in Medicaid will be required to achieve minimum performance levels on standardized quality assessment measures.[23] States and plans are exploring different monitoring strategies to meet these goals.

Our 1998 and 2000 surveys asked about two common strategies for measuring plan performance: the collection of the Health Plan Employer Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA) and NCQA accreditation. Although the majority of plans collect HEDIS measures, few plans are pursuing NCQA accreditation. Generally, it appears that states and plans are making selective use of these tools.

Health Plan Employer Data and Information Set

One way for plans to document their performance for state regulators is by collecting the data elements in the widely used HEDIS measures. In 1998, 60% of the plans reported that they collected all or most of the HEDIS data elements, and only 7% said they collected few or none. Plans sponsored by health centers were the most aggressive in terms of HEDIS data collection, with 86% of these plans reporting that they collected "all" or "most" HEDIS measures.

In 2000, the percentage of the plans that collected all of the HEDIS items or more than is required by the state dropped to 50%. The rest of the plans claimed to collect at least some HEDIS or state-required quality data. The difference between health-center-sponsored plans and safety-net plans with other types of sponsors has also narrowed considerably in terms of HEDIS data collection. Our site visits suggest that plans are collecting fewer HEDIS items because they either do not find some of the measures valuable or because they simply find it impossible to track these data for patients who continually move on and off the Medicaid program as their eligibility changes.

National Committee for Quality Assurance Accreditation

Accreditation by NCQA was, and is, rare among the provider-sponsored safety-net plans. Previously, we suggested that the low rate of accreditation among safety-net plans was probably due to two factors. First, safety-net plans are relatively young and therefore are not prepared to apply for NCQA accreditation. Second, these plans do not seem to face strong incentives to seek accreditation.[21] State Medicaid programs have their own requirements and do not require NCQA accreditation. Furthermore, Medicaid recipients are not likely to consider NCQA accreditation when selecting a managed-care plan. Nevertheless, almost 60% of the plans in the 1998 survey indicated that they intended to apply for NCQA accreditation in the future.

In the 2000 survey, 6 plans reported that they were in the process of applying for NCQA accreditation. We learned from our case study visits that 1 of these plans is at least 1 year away from submitting a formal application to NCQA. They are "in the process" of preparing their information system, utilization review, and quality programs for NCQA review. We also identified 4 plans that had NCQA accreditation in the past and decided not to renew it.

Our site visit plans gave a mixed review of NCQA accreditation. On the one hand, most plans told us that formal NCQA accreditation is not worth the effort. Most of these plans track selected HEDIS measures and incorporate some of the practices encouraged by NCQA, but they did not think benefits of accreditation were worth its substantial costs. Some of the plans that decided to drop their accreditation also believed that NCQA was not appropriately sensitive to the difficulties faced by Medicaid plans with regard to data collection and tracking. On the other hand, the plans that were forced to receive NCQA accreditation to qualify for a state license believed that the accreditation process improved the plan.

Improvement in State-Plan Cooperation

According to our survey and site visits, state regulation of Medicaid managed-care plans has evolved into more of a partnership. Nearly 40% of the plans described their relationship with their state as "collaborative," and 52% described the state as "accessible." A number of state and plan officials told us that the exit of commercial plans from the Medicaid program encouraged states and plans to work more cooperatively (for more details on this point, see reference 20).

CONCLUSION

Our 2000 study found fewer safety-net plans, but the survivors are larger and enjoying greater financial success than the plans we surveyed in 1998. A much higher percentage of plans are either making money or breaking even. The total enrollment in most of these plans has also increased since 1997, although it appears that Medicaid continues to represent the majority of enrollment for most plans. The improvement in the financial status of safety-net plans can be attributed to a number of factors, but improvements in Medicaid reimbursement rates and other supportive state policies were certainly key factors for most of the plans we visited.

Even though most safety-net plans were profitable and growing in the 2000 survey, one of the most striking findings is the number of safety-net health plans that have either closed or dropped out of the Medicaid program. We believe the

matter of safety-net plan closures warrants additional research, particularly given the importance of safety-net plan stability for the Medicaid program.

Sponsor organizations continue to play an important role in the delivery systems of these plans, but as commercial managed-care plans leave the Medicaid market, many of the safety-net plans are expanding their enrollment and networks. Yet, while these plans are adding a growing number of providers who see a small number of the plan's Medicaid enrollees, the bulk of care is still provided by sponsoring organizations. This is consistent with the goal of safety-net provider organizations to maintain their Medicaid business, but it suggests that the goal of mainstreaming remains elusive for the Medicaid program.

Although safety-net plans do not appear to be offering widespread access to mainstream providers, they do appear to be moving slowly, but steadily, toward more sophisticated efforts to manage the care of their enrollees. Safety-net plans report that they are moving away from some of the most aggressive utilization-management techniques associated with managed care in favor of data-driven efforts. Plans are attempting to work in partnership with their providers to improve the delivery of care,[24] a trend that is consistent with changes in the commercial managed-care market.[25] These efforts include sharing data about practice patterns, quality incentive programs based on various performance measures, and the expanded use of case management and disease management.[20]

Commercial MCOs continue to play an important role in most state Medicaid managed-care programs, but concerns about the long-term commitment of these plans to Medicaid make the question of safety-net plan stability and competence increasingly important. Our study suggests that, with supportive state policies, safety-net plans are capable of remaining viable. Contracting with safety-net plans may not be an efficient mechanism for allowing Medicaid recipients to "enter the mainstream of American health care," but it may provide an effective way to manage and coordinate the care of Medicaid recipients while helping to maintain the health care safety-net for the uninsured.

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